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VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Comments on the Healthy Michigan Plan Second Waiver

Thank you for the opportunity to comment on the proposed waiver amendment submitted to CMS on September 1, 2015. The Michigan Poverty Law Program (MPLP) is a non-profit law firm in Michigan that advocates on behalf of low-income individuals on a wide-range of issues, including public benefits.

MPLP supports the continuation of the Healthy Michigan Plan (HMP) and wants to assist in making this possible. However, it is our opinion that the current waiver proposal offered by the Michigan Department of Health and Human Services (DHHS) should be rejected by CMS and that Michigan's current waiver, which is already approved and largely successful, be permitted to continue. If CMS rejects the waiver amendment and state legislators are unwilling or unable to negotiate, 600,000 Michigan residents will lose Medicaid coverage. We believe that it is possible to amend Michigan's waiver statute to include provisions that are reasonable and acceptable for legislators, the governor, consumers and CMS.

The waiver request does not promote the objectives of the Medicaid program

- **Cost sharing**
  All waivers must serve a demonstration purpose that promotes Medicaid's objectives, which are to deliver health care services to vulnerable populations who cannot afford the health care services that they need. The second waiver would raise cost sharing requirements from 5% to 7% and raise contributions to a health account from 2%

to 3.5 % of household income. This is a significant increase and will lead to reduced enrollment. For this reason, the federal government has not allowed states to impose cost-sharing charges beyond what Medicaid rules already allow.[1] The requested increases are above that cap and CMS has never approved premiums above 2% of household income. A large body of research shows that cost sharing and other mandatory contributions act as barriers to obtaining and maintaining coverage for people with low-incomes[2]. If the state is permitted to increase contributions and cost sharing requirements, it will have a drastic impact on enrollment and access to health care.

Under the HMP, contributions and cost sharing are equal to about the same level charged through the Marketplace in states not expanding Medicaid. This is consistent with other states that have expanded Medicaid through a waiver. CMS has approved Section 1115 waivers in six states: Arkansas, New Hampshire, Indiana, Iowa, Michigan, and Pennsylvania. With the exception of authorizing some increased cost sharing for the non-emergent use of an emergency room, CMS has limited cost sharing to copayment and coinsurance levels already permitted in Medicaid under federal law, capping it at 5% for individuals above 100% of the FPL. By requiring an increase in cost-sharing requirements up to 7% of income, the state is asking CMS to approve an amount that it has never approved. Studies have found that higher premiums reduced enrollment of a CHIP population and had greater effects the lower the family income[3]. Deterring enrollment is inconsistent with the goals of a Section 1115 waiver and with the

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[1] http://www.cbpp.org/research/approved-demonstrations-offer-lessons-for-states-seeking-to-expand-medicaid-through-waivers

[2] Ku, L, and Coughlin, T, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences." *Inquiry* 36(4):471–480, 1999–2000 Winter.

[3] Kenney, G, Allison, R A, Costich, J F, Marton, J, and McFeeters, J, "Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States" *Inquiry* 43(4):378–392, 2006–2007 Winter

Affordable Care Act. CMS should not approve an increase that is above the federal Medicaid limit and will contribute to less individuals accessing health care services.

Federal exchange enrollment with no state subsidy is not legally permissible

By law, Medicaid eligible individuals are not eligible to receive Marketplace subsidies. CMS will not approve such a request as it would put the entire cost of care on the federal government. It would be paying the entire subsidy with no state match. CMS has approved waivers that permit premium assistance to purchase private insurance, but none where the state pays nothing and the consumer is left to seek tax credits and cost-sharing subsidies on the federal exchange.

- **No wrap around services**

A second problem is that the waiver request does not state that enrollees in the Marketplace will be eligible for wrap around services available under Medicaid. In dealing with prior requests for waivers, CMS has stated that premium assistance must be combined with a guarantee that Qualified Health Providers (QHPs) will provide any necessary wrap around benefits that are available under Medicaid. This includes non-emergency transportation, periodic screening, diagnosis and treatment (EPSDT) of children and young adults for conditions such as lead poisoning, malnutrition and mental illness, as well as limits on co-pays and premiums, which can prompt people to do without care. For the low income population with no extra income, these services are a crucial component of comprehensive care. The state proposal does not require wrap around services and should be rejected by CMS.

- **No right to a fair hearing**

Finally, the waiver does not guarantee fair hearing rights. Previous waivers approved by CMS have language stating that they will comply with all notice requirements and hearings and

appeals rights afforded to demonstration participants. Enrollees will lose these protections in the private market as they will no longer be considered Medicaid recipients.

A state plan that offers individuals enrollment in the private market, using federal tax credits and federally subsidized cost sharing with no state contribution or federal protection, is not an acceptable Medicaid waiver.

The underlying statute does comply with legal standards

MCL 400.105d(20) states that individuals who are between 100% and 138% of poverty and who have had medical assistance for 48 cumulative months will be asked to choose between purchasing health insurance through the federal health benefit exchange or remaining on the HMP but have their cost sharing increased. MCL 400.105d(21) states that individuals who are approaching time limits will be given a 60 day notice that they must choose an option. MCL 400.105d(22) states that DHHS will create a process for individuals subject to the 48 month time limit who fail to choose an option. There are at least two problems with the language of the statute:

- **How are the 48 months counted?**

There will be more than one group of individuals who receive Medicaid through the HMP for 48 continuous months. Some will have income below 100% of the federal poverty line (FPL) for all of the months. Others will be above 100% but below 138% for all 48 months. Finally, there will be a group whose income has vacillated above and below 100% of the FPL. The law does not state whether individuals who are between 100 and 138% of poverty *after* 48 months of continuous HMP coverage must have received **all** 48 months of coverage in the higher income bracket in order to be subject to the provisions of the statute. Will all months of coverage be counted towards time limits because an individual is above 100% when month 49 begins? Or do the provisions in MCL 400.105d(20)(a) and (b) apply only to individuals who accumulate a

total of 48 months in the higher income bracket? The statute does not clearly define what 48 months of coverage means when applied to individuals or families whose income has fluctuated over the years. CMS should not approve a waiver with ambiguous and vague language.

- **No ex parte review before disenrollment - MCL 400.105d(23)**

The statute states that if the waiver request is not approved by the Unites States Department of Health and Human Services by December 31, 2015, medical services under the HMP will no longer be provided. It states that enrollees will be given notice by January 31, 2016, that their coverage will end as of April 30, 2016. This violates federal law as it does not provide for an ex parte review. Statutes, implementing regulations, and relevant case law require DHHS to conduct a redetermination of eligibility for individuals enrolled in the HMP before terminating benefits[4]. If the waiver is not approved, DHHS is required to give notice to every person enrolled in the HMP that their current coverage is ending and to assess that person for other categories of Medicaid. For instance, individuals currently enrolled in the HMP may have disabling impairments and income levels that make them eligible under traditional Medicaid. Since the HMP eliminated categorical eligibility, a determination of disability is not necessary. However, if the HMP ends, the law requires that recipients must be notified and all necessary assessments must be conducted in order to see if coverage can continue. The statute does not provide for an ex parte review before terminating coverage under the HMP and is therefore illegal. CMS cannot approve a waiver that is illegal.

Conclusion

The proposed amendment to the Healthy Michigan Plan, as set forth by statute, cannot be accepted by CMS. It contains provisions never before approved as part of the Medicaid program and does not further the goals of providing health care coverage to low-income households. It is

[4] 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930(b)

imperative that legislators, the governor, and advocates work together to revise the existing statute to either change its requirements or eliminate it entirely so that the Healthy Michigan Plan may continue uninterrupted.

Thank you for your consideration of these comments. Please feel free to contact me with any questions.

Sincerely,

MICHIGAN POVERTY LAW PROGRAM

Lisa Ruby
Staff Attorney